Tier One COVID Response Assessment

(Day Centers, Shelters and Transitional Housing)

1. Name of person collecting assessment information?

2. Please Provide Program Contact Information

Name of Organization *(exactly as it was provided to you)*

Facility Name *(exactly as it was provided to you)*

Contact Name

Contact Email *(optional)*

Contact Phone Number *(optional)*

3. Does your program currently operate 24/7?

- Yes
- No

If 'No', what do you need to expand to 24/7 operations?

4. Do you currently have separate rooms or large well ventilated room(s) to support symptomatic people?

- Yes
- No

Other Comments

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5. **(Skip, if 'Yes' to Q4)** do you have the ability to create a space on site to support and isolate symptomatic people?

- ◯ Yes
- ◯ No

If 'Yes', what does your program need to create a space?

6. How many syptomatic people could be supported/isolated at your site?

7. What type of bed(s) does your shelter currently use?

- ☐ Mats on the floor
- ☐ Bunk beds
- ☐ Single beds in shared dorms
- ☐ Private unit (kitchen/bed/bath)
- ☐ Private unit with shared bathroom and/or kitchen
- ☐ Cots
- ☐ N/A Not an overnight program
- ☐ Comment

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8. **(For Overnight Shelters Only)** Do you currently have a 'Head to Toe' sleeping set up?

- Yes
- No
- N/A

Comment

9. **(For Overnight Shelters Only)** How much space do you currently have between beds or mats?

- Less than 6 inches
- 6 inches to 1 foot
- 1 to 3 feet
- 3 to 6 feet
- More than 6 feet
- N/A

Comment

10. **(For Overnight Shelters Only)** Do you have dividers between beds?

- Yes
- No
- N/A

Comment

11. Does your program have an established cleaning schedule?

- Yes
- No

Comment

12. How often do you clean the following areas?

	Frequency
Beds and/or bedframes	
Mats and/or mattresses	
Linens/blankets/bedding	
High touch surfaces (counters, door knobs, etc.)	
Bathrooms	
Kitchens and/or Food Service Areas	

Comment

13. Do you have medical capacity on site?

- ○ Yes, part-time nursing staff
- ○ Yes, full-time nursing staff
- ○ Yes, clinic with medical staff
- ○ No

Comment

14. Do you have behavioral health support on site?

- ☐ Mental Health
- ☐ Substance Use
- ☐ Peer Support
- ☐ No

Comment

15. Under current opearations, is your program able to designate staff to support symptomatic people?

- Yes
- No

Comment

16. What does your program need to be able to designate staff to support symptomatic people?

17. Do you currently have information about COVID-19 posted in your program?

- Yes
- If 'No' provide flyer linked in Q17.

18. Do you currently have hand washing stations?

- Yes, mobile stations
- Yes, fixed stations
- No

Comment

19. Do you currently have sufficient cleaning supplies?

- Yes
- No

If 'No", what do you need?

20. Are there other supplies or resources your program needs to respond to COVID-19?

21. Do you have any other comments or questions about COVID-19 you'd like to share?